MINUTES OF THE NORTH LONDON STP HEALTH AND CARE CABINET

17:00-19:00 ON WEDNESDAY 15 November 2017

Haringey Civic Centre, Wood Green

Members	Role	Attended	Deputy sent	Apologies
Jo Sauvage	Co-Chair and Clinical Lead for STP; Clinical Chair Islington CCG	✓		
Richard Jennings	Co-Chair and Clinical Lead for STP	✓		
Neel Gupta	Clinical Chair Camden CCG			✓
Saania Bhatti	Deputy for Barnet CCG Clinical Chair; Barnet GP			✓
Mo Abedi	Clinical Chair Enfield CCG			✓
Peter Christian	Clinical Chair Haringey CCG			✓
Jonathan Bindman	Medical Director – BEH MH NHS Trust	✓		
Vincent Kirchner	Medical Director – C&I NHS Foundation Trust			✓
Paul Hopper	Divisional Medical Director – CNWL NHS FT			✓
David Hicks	(Interim) Medical Director – GOSH FT			✓
Geoff Bellingan	Medical Director – UCLH FT			✓
Kevin Cleary	Medical Director – North Mid			✓
Stephen Powis	Medical Director – Royal Free London FT	✓		
Ricky Gondhia	Clinical Director, CLCHT			✓
Declan Flanagan	Medical Director – Moorfields Eye Hospital NHS FT			✓
Aresh Hashemi-Nejad	Medical Director – RNOH NHS Trust			✓
Rob Senior	Medical Director – Tavistock and Portman NHS FT			✓
Flo Panel-Coates	Nursing Representative; Chief Nurse - UCLH			✓
Helen Donovan	Nursing Representative; Registered Nurse & Barnet CCG Governing Body Member	✓		
Claire Johnston	Capital Nurse/HEE Representative;			✓
Sarah McClinton	Director of Adult Social Services (Camden Council)	✓		
Ray James	Director of Adult Social Services (Enfield Council)			✓
Carmel Littleton	Director of Children's' Services (Islington Council)			✓
Tony Theodoulou	Director of Children's' Services (Enfield Council)			✓
Julie Billett	Director of Public Health, Camden and Islington			✓

Pauline Taylor	Medicines / Pharmacy lead	✓		
Katie Coleman	Primary Care Lead for NCL	✓		
Charles House	Specialised Services Lead for NCL	✓		
Samit Shah	Urgent Care Lead for NCL			✓
Laura Leadsford	Allied Health Professional lead			✓
Fiona Yung	Allied Health Professional lead			✓
TBC	GP Federation lead for NCL			
Mike Roberts	UCL Partners representative			✓
Sanjiv Ahluwalia	Health Education England representative			
Debbie Frost	Clinical Chair, Barnet CCG			✓
Yogi Amin	UCLP QI lead			✓
Ash Moore	Specialised Commissioning London Region			

Attendees	Role	Reason for attendance
Helen Pettersen	NCL CCGs Accountable Officer	STP Convenor
Will Huxter	NCL CCGs Director of Strategy	STP Lead
Richard Dale	Head of Programme Management	STP PMO
Ash Moore	Specialised Commissioning London Region	NHS Spec Comms rep

No.	Agenda Item	Action owner
1.0	**Welcome**	
	RJ welcomed everyone to the meeting. Introductions were made and apologies noted. The meeting was QUORATE.	
2.0	**Review of minutes and actions from the previous meeting**	
	The minutes of the last meeting held on 18 October 2017 were agreed. The action log was agreed as complete.	
3.0	**STP Programme update**	
	Will Huxter(WH) provided a brief update covering the following issues: • **18/19 Delivery plan refresh** WH outlined that the workstreams are currently going through a planning refresh looking at the milestones for 2018/19. This included a focus on the finance and activity implications of the changes outlined in the delivery plan. These updated plans, when complete, will be brought to HCH with both the aggregate view and the detail for review and comment. The key emphasis is to align plans across organisations to maximise the impact of the programme. There will be a need to ensure that the critical interdependencies between programmes are managed effectively.	

	• **Provider CEO meeting on 24 November** Will Huxter (WH) outlined that the process last year of looking at what difficult choices the system need to make is likely to be repeated. There is a meeting on the 24th November for the provider chief executives to look at this in detail. This will be fed back to the next Health and Care Cabinet. Helen Pettersen (HP) outlined that some of this would be linked to the development of accountable care systems (ACS) and there was a need to consider how this might apply to us. As although London does not lend itself to ACS style working (We have overlapping areas for catchments and responsibility), there is value in the principle of picking things that we can all work together to align incentives for across NCL. It was noted that an area like clinical advice and navigation and reducing unnecessary outpatient appointments would benefit all, but would require organisational payments and incentives to change to have a large impact. Jo Sauvage (JS) also provided some feedback from a recent STP clinical leader's event that she and a few colleagues attended noting that this was a theme of the event. Charles House (CH), also agreed the outpatients would be a good option for system focus – with the aim of providing continuity of service, not solely minimising referrals. Ash Moore (AM) put forward the potential to work on the Acute Kidney Injury work - that spans specialised, secondary and primary care pathways – as one of the chosen priorities. This focusses on evidence based practice and reduction in variation of early treatment to prevent AKI and ongoing dialysis needs. The cabinet discussed the importance of understanding areas of greatest impact and variation, where evidence and tools can be used to drive improvements. Such as treatment escalation plans and using predictive tools in primary care. In addition the group discussed the importance of coordinated care across organisational boundaries - especially at the end of life care. This would improve the quality of care for patients and is a more effective use of resources. HP asked the group if the Health Information Exchange (HIE) would fix this issue. The group agreed it needed to be a priority for this. RJ also stated that there was still a lot we could do to fix our current systems. While this was in progress.	
4.0	**Simplified discharge**	

	As Sam Shah (SS) sent apologies, this item was presented by JS. The cabinet discussed the issue of consent for the discharge to access model being implemented by the Urgent and Emergency Care workstream, including any implications or restrictions on data sharing. The cabinet discussed the need for the person and their family to be fully informed and thus able to give consent. They also discussed the difficulties if patients or families do not feel able to provide consent and the role the wider care team play in this. They also discussed the merits and constraints of explicit, explicit and written consent in different contexts. The cabinet felt obtaining consent to share information across the entire clinical multidisciplinary team (MDT) was an important way of supporting the management of complex cases and sharing data appropriately can improve the quality of care and improve safety. This should include appropriate involvement of a person's GP in the discharge process. In conclusion, the cabinet agreed on the following points: It was important to differentiate between implied consent, verbal consent and written consent in the context of discharge to assess from hospital to another place. The important element is the quality of the conversation to ensure that that the consent is informed and person-centred. Patients should give explicit informed verbal consent to information sharing with the multi-disciplinary care team which can then be documented and utilised to support the discharge to access. In this context, it is understood in some cases consent will not be immediately obtained rapidly to move to another venue for care. In this case, in line with the principles above, this will need to handle locally by proper multi-disciplinary meaningful discussion to resolve and reconcile the situation. Recognising that in some cases this can be very difficult. Alongside this, wherever possible, patients should give explicit informed verbal consent to information sharing with the multi-disciplinary care team which can then be documented and utilised to support their discharge. With regards to the issue of information sharing, the Caldecott principles provide the essential guidelines. And that the Caldecott Guardian can give advice on the application of Caldecott Principles in difficult cases.	

	In a situation where a person lacked capacity, the process of consent to information sharing would fall within the scope of the Mental Capacity Act Consent to share information across the entire MDT was felt to be an important way of supporting the management of complex cases, where the person does not consent to transfer to another place of care as part of the discharge to assess process. **JS agreed to feed the above back to the UEC workstream lead Jenni Frost**	**JS**
5.0	**NICE Support offer**	
	Jane Moore, Jane Moore, Implementation Consultant National Institute for Health and Care Excellence (NICE) presented on the support offer from NICE, outlining how it can support the key transformation programmes through its evidence base. There is an offer from her and the London team to undertake bespoke evidence reviews to input into local strategy work, pathway redesign and engagement. There was discussion on how best to work with Jane's team as there are nine of them across London. There have been bespoke focussed bits of work recently completed on transitions (from paediatric services to adult). Katie Coleman was keen to ensure this work linked into the QI network across NCL as well as the development of community health integrated networks (CHINS) and quality improvement support teams (QISTs). The group asked about the link to evidence based savings – this in not yet part of the offer, but in development.	
5.0	**Workforce update**	
	As Claire Johnston (CJ) sent apologies, this item was presented by Helen Donovan (HD). HD presented the progress being made across the programme that had been selected as good practice and evidence to be submitted to the Health Select Committee on nursing workforce. This outlined: 1) The vision and approach to achieving a sustainable nursing workforce 2) Streamlined employment for final year students and 'preceptorship plus' for new qualifiers 3) Early years' career tracking and 'nurse friendly' employment 4) Managed career progression and bridging the generational divide	

	Helen also outlined the approach to the work being taken to try and manage the risk across health and social care as both workforces are at the heart of the STP. JS highlighted a recent email from Vinod Diwakar (VD) Medical Director, NHS England (London) that paid compliment to the strong clinical leadership in the STP from across clinical disciplines. Including the STP named nursing leads for leadership and Quality. VD was interested in learning more to understand how this can also be done well in other regions and areas. HD observed that there was a chance to broaden the leadership further through wider involvement of social care. Although it is not clear how best to go about this.	
6.0	**AOB and date of next meeting**	
	RJ congratulated Prof Stephen Powis on his new role as medical director of NHS England. There were no other items of other business discussed. The next meeting will be 6 December 2017 Whittington Education Centre.	
CLOSE: The meeting closed at 7:00pm.		